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contracts; correct?
A. And I think those four contracts were ones that I was able to get from defendants.
Q. None of those are Cigna contracts; correct?
A. I would assume not, but I -- I am trying to think whether --
(Pause.)
(The witness viewing Exhibit Hartman 023.)
A. -- in my rebuttal reports I had seen Cigna contracts, but that is something I can check.
Q. Okay. Let's go back to Ms. Herbold's deposition. She is also with Cigna; correct?
A. Yes. It appears that as far as I can tell she is responsible for strategy and policy as well as financial analysis for practitioner reimbursement, and so she is an assistant VP practitioner reimbursements. She has been that since 2004, so she has been doing that job since fairly recently, and --

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Q. I want to direct your attention to page 21 of this deposition beginning at line 8.
(Witness complying.)
Q. "Question: Can you tell me the range below AWP that these rates and the Cigna national standard injectable reimbursement rate was varied?
"Answer: Typically 15 percent. We have codes that are up to 45 percent below AWP."
Do you see that?
A. I do.
Q. So Cigna's contracts do not fall within the plus or minus 15 percent of AWP range on which you premise your report; correct?
MR. SOBOL: Objection to form.
A. Well, certainly their typical contract does. Now they claim they have codes up to 45 percent below AWP, and I would assume that is for a multi-source, and I would have to -- I would have to -- as to typicality, I see 15 percent. As to whether -- how much of an exception 45 percent is, and this is again as of 2004, and there certainly have been more multi-source drugs

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recently, in the last five years of the physician administered, so I would assume that that applies to multi-source.
Q. So that would be another example of payer expectation with respect to multi-source differing from the expectation with respect to single source?
A. This is one piece of evidence regarding as of 2004 what a relationship would be for a multi-source product.
Q. Next I want to show you the transcript of the deposition of Joe Spahn taken November 30, 2004.
MR. EDWARDS: This will be Exhibit Hartman 031.
(Deposition transcript of Joe Spahn taken on November 30, 2004 marked Exhibit Hartman 031 for identification.)
(Handing Exhibit Hartman 031 to the witness.)
BY MR. EDWARDS:
Q. Mr. Spahn is with Anthem. Do you know

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what Anthem is?
A. It is my recollection that Anthem is a Blue Cross/Blue Shield, but I would have to confirm that. Oh, yes. There it is. Anthem Blue Cross/Blue Shield.
Q. Anthem is an amalgamation of a number of Blue Cross/Blue Shield entities; correct?
A. That -- it's -- I think that's correct. I don't know how many, and I would have to confirm that.
Q. Do you know whether Anthem is at this point the largest payer in the country?
A. As of today, you mean?
Q. Yes.
A. I don't know.
Q. What I want to do is direct your attention to the testimony that begins at page 93, line 6.
"Question: Now you testified earlier that Anthem has -- does not know exactly what providers are paying to acquire drugs; correct?
"Answer: Correct.

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"Question: That is not something that -- withdraw that.
"Anthem does not require providers to disclose their acquisition cost for drugs as part of their contracts with those providers; correct?
"Answer: Correct.
"Question: So providers' acquisition costs for drugs do not form part of Anthem's determination of what it will reimburse them in relation to drugs?
"Answer: Correct.
"Question: The reimbursement is driven entirely by the fee schedule?
"Answer: Correct.
"Question: Regardless of what the specific providers' acquisition cost for those drugs may be?
"Answer: Correct.
"So if, for example, Anthem were to learn that a particular provider were getting a discount or a rebate on a particular drug that lowered his acquisition cost for that drug, that

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wouldn't change the amount that Anthem is reimbursing that practice in relation to that drug; right?
"Answer: No.
"Because the reimbursement amount is tied to the fee schedule?
"Answer: Right.
"Question: And if Anthem were to learn that providers in a region were getting a discount or rebate from a drug manufacturer in relation to a particular drug, again that wouldn't change the amount that Anthem reimburses because that is tied to the fee schedule?
"Answer: That's correct.
And then continuing on page 97, beginning with line 17, "Prior" -- question:
"Prior to the break, we were talking about providers' acquisition cost and the fact that they are not relevant to Anthem's reimbursement amounts. Do you recall that testimony?
"Answer: Yes.

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"Question: Okay. And part of that was that Anthem has no information about the providers' acquisition costs? Right?
"Answer: Correct.
"Question: So it is fair to say that Anthem has no particular expectation that providers' costs would be, you know, 10 percent, 30 percent, 50 percent, something more, something less than the amount they're reimbursed in relation to those drugs? Right?
"Answer: Yes."
Now based on that testimony, would it be fair to say that your opinion that payers have expected that AWP is larger than ASP by a reasonably predictable amount would not apply to Anthem?
A. What this says to me is what occurred over the '90s and into the early 2000s, and that is that there were a set of expectations going into that period of time of what the relationship was, and that formed expectations as cited by Mr. Young as laid out in the 1992 OIG report for

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single-source drugs, as reflected in contracts that were negotiated over this entire period of time, and what was also the discussions that were going on Congressionally about Medicare. That there were expectations in place that governed reimbursement of both Medicare and third-party payers looked to Medicare and discounts off of AWP and how they reimbursed. There was a growing awareness with both the legal action and once managed healthcare dealt with some of the larger cost issues, like hospitalization and physician costs, they started focusing on issues about prescription drugs and then physician-administered drugs.
And this says to me that Anthem, going into this, that they didn't -- they don't have the information they need to know more than relying on the general kinds of rules of thumb that have characterized this market and that has been able to be abused by the manufacturers, and so they have locked into a computer system and a reimbursement system a set of AWPs and

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reimbursements off of AWPs, and I know there are private third-party payers that are starting to evaluate this kind of issue now and starting to learn that there is a bigger gap than they thought, but this is something that is only recent, and it hasn't been -- this is precisely why this has been a lucrative area to exploit by the kind of behavior that is alleged on the part of manufacturers.

Q. If you look at pages 8 and 9 of this deposition, you will see that Mr. Spahn testifies that he has served as senior healthcare consultant to Anthem since 1992. Do you see that?

A. I do.

Q. And he doesn't say in the testimony that we just read that his views of this matter have changed over the period of time since 1992 to the present, does he?

A. He -- you are asking -- there is -- there is -- there is hundreds -- there is 174 pages of deposition here, and for -- I'm not going to attempt to characterize that particular set of

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quotes.

What page was that again? Oh, here we go.

Q. The quotes we read were from --

A. No. I see it. I have got it.

Q. -- I think 93 to 97.

A. The quotes?

Q. Or 98. Pages 93 to 98.

A. Okay. I thought -- yes. Not years.

Yes. I mean I am -- I am -- I would assume that as of now, 2004-2005- 2006, that these -- that providers are beginning to realize that these expectations, the expectations that they have relied on to write their contracts, that is reflected in all of the testimony that I have cited and the surveys that I have cited and what the Judge has relied on, reflected a period of time where the spreads have obviously been exploited in very dramatic fashion, as recognized by Dr. Berndt, and payers are beginning to say, you know, there is something -- we need to be thinking about acquisition costs. I don't know

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what it is right now, and because our systems of reimbursement are hard wired to AWP, I don't know what it is. We can't work with that. But I know that third-party payers are beginning to try to, precisely because they -- the extent of the problems alleged in this matter are becoming clear.

Q. What is the basis for your testimony that Mr. Spahn's expectations have changed since 1992?

MR. SOBOL: Objection to the form.

A. I didn't say Mr. Spahn's. I am saying that the -- as a -- as a matter of information, that is -- that is compelling, we have talked about this 1992 OIG report that the -- how much that was disseminated as to the multi-source spreads is unclear -- is unclear to me, but what is clear and has become clear, as I have said in paragraph 53A, and these are events where we have had the Lupron behavior becoming known, that was behavior going on in the '90s, and exploiting understandings of reimbursement in the '90s, and

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it became clear in 2000 -- with the litigation, and then with the settlement agreement with 2001, the sentencing memorandum, there were hearings before the House Energy Subcommittee, and if you will give me leeway to find one more.

(Pause.)

(The witness viewing Exhibit Hartman 023.)

Q. Would you agree with me that --

A. I would like to get just this one last statement in the record, if I could.

(Further pause.)

(The witness continues to view Exhibit Hartman 023.)

A. And there is probably a time limit at some point.

MR. EDWARDS: While you are looking, why don't I have the reporter mark the next deposition exhibit, which is Exhibit Hartman 032.

(Deposition transcript of Edward Lemke taken on January 11, 2005 marked Exhibit Hartman 032 for identification.)

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THE WITNESS: Yes. I can't find it.
MR. EDWARDS: It is the deposition of Edward Lemke, taken on January 11, 2005.
THE WITNESS: Oh, wait. I found it. It is also the quote put forward by Dr. Berndt at page 42 of his report where again he is stating fairly recent understandings, and he says, this is in footnote 12, he says, "In a different industry publication, an executive of Advanced PCS reports that in his experience health plans become flabbergasted on what they are paying for years on drugs on the medical side because of dramatic price markups."
So this is again another summary of a recent understanding of what has occurred over the period of the '90s.
Q. Take a look at the deposition of Edward Lemke of Humana, which we have marked as Exhibit Hartman 032.
(Handing Exhibit Hartman 032 to the witness.)
Q. Have you read this deposition before?

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A. I think I -- I think I have seen parts of it. I think in terms of reviewing defendants' experts, I had read part of this, but I can't recall.
Q. I just want to direct your attention --
A. I am sorry. I just want to find out who this person is before we --
Q. You may want to look at page 18, where Mr. Lemke states that he is director of fee schedule management for Humana.
(Witness complying.)
A. Okay. Humana. Okay.
Q. Let me ask you to look at page 123, beginning at line 17.
(Witness complying.)
Q. "Question: Is it Humana's expectation that the amounts that providers pay to acquire drugs are a fixed percentage less than the amount Humana reimburses in relation to those drugs?
"Answer: The expectation that first of all that it's fixed, no. The expectation that good business practice, and assuming providers

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that we do business with practice good business practices, is that they would only accept payment that is at or above their costs."
A. I --
Q. "That is my only expectation --"
A. Counsel, I am sorry. I missed the -- I thought I had the page, and I have been looking for the words. Could you tell me?
Q. Sure.
A. Just start me.
Q. It starts at 123.
A. Page 123, okay.
Q. Line 17.
A. Okay. I am sorry.
Q. And what I just read you is line 17 on page 123 through line 4 on page 124.
A. Okay.
(Pause.)
(The witness viewing Exhibit Hartman 032.)
Q. Where he says it is his only expectation that they would want payment at or above their

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costs.
And then continuing on:
"Question: And certainly you have no fixed expectation as to how much higher it would be than their acquisition cost; correct?
"Answer: Correct.
"Question: And indeed that would vary from provider to provider depending on what they paid to acquire drugs and what Humana reimburses them for drugs?
"Answer: Correct.
"Question: The percentage could be 10 percent in one case, 50 in another, 100 in another; correct?
"Answer: Could be."
Now, Dr. Hartman, is it fair to say that your conclusion that payers have expected that AWP is larger than ASP by a reasonably predictable amount does not apply to Humana?
A. No.
Q. Well, if the Court or the jury finds that the testimony of Mr. Brown, Mr. Greenbaum,

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are developed don't provide sufficiently scientific evidence to be incorporated into what I have done here (pointing to Exhibit Hartman 023).

Q. Is there any literature that you can cite to me to support the proposition that in determining market expectations you should disregard the testimony of participants in the market as to what their expectations were?

MR. SOBOL: I object to the form.

A. The -- I think there is a literature that -- certainly there is a whole class of literature that is aimed at what is known as contingent valuation, which is what -- which is a set of surveys and survey designs that attempt to elicit the feelings of market participants about their expectation or their valuation without having to buy that -- actually enter into an economic transaction that would make -- that would reveal what the final result of those expectations were, and it has been demonstrated that those kinds of surveys and that kind of information can be very unreliable, and that's a

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form of expectations or beliefs about what willingness to pay or certain things.

So the -- as a general rule, economists will look to revealed preferences and what is revealed in actual transactions, contracts, prices, what is actually paid, what has actually been written into a contract as the summary of expectations.

Q. Well, are there particular economists that you can identify who have expertise in this area of contingent valuation that you just mentioned?

A. There is -- there are economists that have implemented it -- and I can't really remember the names now. There are economists that have argued against the validity of that kind of work, and there is a -- there is a paper -- there is a monograph out that includes some authors, Jerry Hausman and some other authors. I forget. I think it is called -- it is -- I can't remember the press name.

Dr. Gaier probably knows the press name.

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Where is he?

THE WITNESS: He doesn't know the press name.

A. North Holland is -- and it is a critique of contingent valuation.

Q. And I take it that this theory of contingent valuation is one of the things that you would rely on in rejecting the deposition testimony of Mr. Brown, Mr. Greenbaum, Mr. Lemke, and Mr. Spahn that we have discussed earlier today?

MR. SOBOL: Objection.

A. What? I'm not quite sure the -- the -- the approach of contingent valuation is to survey persons and say, "Well, what do you think you would do in this situation, what would you pay, what would you be willing to pay."

And that has -- that is not unlike, you know, what did you think the costs were?

And there has been -- so I am not proposing -- I am saying that that is an approach that would say, "Go after expectations."

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I am saying that a lot of economists have found that that is -- that there are problems with that, and it is not reliable. Once you allow persons that express expectations or valuations to actually put money on the table and sign a contract or pay a price that it differs quite -- quite a bit from what the expectations were. There is expectations that inform a final decision, but what I focused on here was evidence on final decisions, and I was focusing on evidence in the -- in the '90s, not the depositions you are telling -- you are pointing out to me are all, you know, very recent, and expectations have changed over the last 15 years.

Q. Can you identify any payer who has testified that it was his expectation that AWP exceeded ASP by a range that did not exceed 30 percent?

A. I just cited to in the -- in attachment K that were -- that were dealing with self-administered drugs.

Q. And that is as good as you can do?

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A. I just cited to in the -- in attachment K that were -- that were dealing with self-administered drugs.

Q. And that is as good as you can do?

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MR. SOBOL: Objection to form.
A. I would have to -- the -- and then I have also extended Mr. Young's discussion to the issues of Medicare, so in terms of as good as I can do, I would also appeal to whomever Mr. Young was relying on, and I would want to review my rebuttal declarations in the affirmative matter, because there were the same -- the same kind of selective quoting was done by your witnesses in that set of pleadings, and when -- when looked more closely at the whole context of the deposition, I was finding -- I found that they didn't support what was being contended they supported.
So you have showed me some -- you have showed me a few quotes, and I -- they -- they don't tell me anything that contradicts this here, except some people didn't know what the acquisition cost was at some point in time.
Q. But as you sit here today, you cannot identify any third-party payer who has testified that he or she expected that AWP exceeded ASP by

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30 percent; correct?
A. The -- the contracts that I have reviewed that are in my attachment C, the contracts that are reviewed in the Dyckman report, the contracts that are reviewed in the University of Chicago NORC survey or analysis all indicate to me that the expectations were that the -- that the spreads were within the yardstick that I have put forward. So what has been revealed by their contracting behavior tells me that that is what they have expected.
Q. I am looking for a name, Dr. Hartman. Can you identify by name any third-party payer who has testified in this case that they expected AWP to exceed ASP by a range that did not exceed 30 percent?
MR. SOBOL: Objection to the form.
A. I would have to go back and look at that -- those materials. I can't come up with a name right now.
Q. We were talking earlier about the methodology that economists use, and I believe you

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testified that basically what you do is you start with a hypothesis and then you test to determine whether that hypothesis is correct or incorrect. Is that the case?
A. If you're talking about hypothesis testing and formulation of hypotheses, that is something that economists do.
Q. What would it take to prove that your expectation theory is incorrect?
A. If I saw contracts -- if I saw contracts that were saying we are now going to reimburse at acquisition cost, if I saw contracts as -- if I saw the end of a revealed preference exercise that occurred at Medicare and will no doubt lead private third-party payers to start reevaluating the way they are doing their reimbursement and what their expectations are, when I see they start to say, look, we want to reimburse on acquisition cost and there is a definition of what that means, that will say to me that they have -- that they are now revealing an understanding of the fact that these spreads are well above what the -- what

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we thought they were.
Q. Well, but what if it's not their approach to reimburse based on acquisition cost?
MR. SOBOL: Objection to the form.
A. Well, you just asked me what would be a piece of evidence that would indicate that -- what would indicate to me that -- that they -- that they realized that these spreads were larger than what -- what the evidence that I have put forward shows, is if they're doing their job, they're not -- the -- they're going to change the way they're reimbursing for physician- administered drugs, and I am going to see that in the contracts, in the way that I see it -- in the way that -- what we are finding in the physician- administered drug area is that the private third- party payers seem to follow the lead of Medicare, and Medicare has finally made a move, and I would expect third-party payers are beginning to evaluate the implications of that kind of move.
Q. Well, you said if they realized that the spreads were not what they thought they were.

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Would knowledge of the spreads disprove your hypothesis?
A. Knowledge of the spreads acted upon through changes in the way contracts are written and reimbursement is paid would indicate to me that they have -- they have -- they have understood it and they have acted -- and they have -- and they have -- and their behavior has been affected by it.
Q. Well, what if a payer had knowledge of the spreads but simply decided not to act on them because they had other objectives that they wanted to achieve with their contracts?
MR. SOBOL: Objection. What is the question?
A. I mean what -- what is the question?
Q. Would that disprove your expectation theory?
MR. SOBOL: Objection.
A. It is -- let's be more specific. I mean let me try to translate this so I can understand what you're saying.

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If I'm -- I'm a third-party payer reimbursing for Lupron, let's say, and I realize that the spread is 400 percent, and I just say, "Oh, screw it, this is accomplishing, you know, I want them to have the money," is that -- is that the notion of the hypothetical you are putting forward?
And then the question is what? Does that disprove? Could you finish your question with that?
Q. Well, it's your theory that payers understood the spread to be 30 percent or less; correct?
MR. SOBOL: Objection to form.
A. They expected and believed the spread to be less than 30 percent.
Q. So if a payer said, "Well, I expected the spreads to be greater than 30 percent," would that disprove your hypothesis?
MR. SOBOL: Objection.
A. The -- if certain payers -- no. It would have to be -- it would have to be -- there

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would have to be behavior that would reflect acting on that.
Q. So mere knowledge of the spreads is not enough?
A. Well, suspicion -- you are -- you are -- you are in an area of psychoanalysis that there is -- are you saying to me that someone observes the sentencing memorandum with Lupron and starts to say -- and says, "God, maybe we're getting screwed here," and so there is some -- there is some growing expectation, that I am hearing you say, but they don't immediately turn out the next day and change their reimbursement pattern, does that mean that there is no liability, whatever? No, it doesn't.
I mean there has to be -- there is a whole set of ways that a company has to act on that, and there is whole systems, information processing systems that are based on AWP and reimbursement off of AWP that have to be altered and changed, so that I might learn something in the market like that and see a particular example,

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but the fact that I don't shift everything right away doesn't mean that I'm still -- that I am saying, "Oh, take whatever you want from me." I'm not a victim of this -- of the behavior.
Q. So is it your testimony that mere knowledge is not enough? There has to be conduct as well as knowledge?
MR. SOBOL: Objection to form.
A. It has to start with knowledge.
Q. And you are saying that because you don't observe conduct in the marketplace that would eliminate the effects of the spread then there must not have been knowledge of the spread either?
MR. SOBOL: Objection.
A. That's one possibility.
Q. You say in your report, "Had the existence of mega-spreads been perceived and understood by third-party payers, those payers would have negotiated more aggressively than they did, leading to lower reimbursement rates."
Do you recall that?

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A. Could you give me the page and the paragraph?
Q. Yes. I think you say it at paragraph 10.
(Pause.)
(The witness viewing Exhibit Hartman 023.)
MR. MUHLBERGER: Page 10.
THE WITNESS: Oh, page 10?
MR. EDWARDS: Was it page 10?
THE WITNESS: Thank you.
A. Yes. Certainly the first, you know, it is like a nine-step program. The first step has to be understanding the extent to which you are overpaying for the drugs. The -- because reimbursement is institutionally -- can change only slowly institutionally. The -- one has to evaluate the costs and the benefits of moving to eliminating those mega-spreads and negotiating in this way, but knowledge is the first step, but it doesn't mean that the -- that as soon as you have a glimmer in your eye, that the lightbulb goes off

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on Lupron, you come to the conclusion and know the full extent across all the drugs for which you are reimbursing. It is sufficiently rational for you and cost effective for you as a third-party payer to switch the system and change your information processing systems to do it.
Q. So you don't know one way or another whether payers were actually knowledgeable about the spreads?
MR. SOBOL: Objection.
A. Everything that I have seen, either where there is some statement about what the -- what the margins that were being made by doctors, the margins that were being made by retailers, people that talked about those types of issues, demonstrate to me that there was an understanding of what the spread was.
I see deponent testimony, as you have put in front of me, that I really can't make much sense out of because I don't know -- they are not getting specific enough. There needs to be a set of follow up questions on those, for those

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deponents.
Q. But you are not in a position to say that at least some payers did not understand that there were mega-spreads?
MR. SOBOL: Objection.
A. It -- you are saying -- I cannot -- I cannot make the statement that no one, no payer, knew that there weren't mega-spreads. I, you know, I don't know whether they did or they didn't.
Q. Okay.
MR. EDWARDS: And indeed let's take a look at an article from the March 1997 issue of Cancer Economics, which I will mark as Exhibit Hartman 033.
(Excerpt from Cancer Economics, March 1997 marked Exhibit Hartman 033 for identification.)
(Handing Hartman Exhibit Hartman 033 to the witness.)
BY MR. EDWARDS:
Q. Have you ever seen this article before,

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Dr. Hartman?
A. I have not that I recall.
Q. Do you know who Dr. Lee Newcomer is?
A. I am trying to find that name. Is it on the front page here? Lee Newcomer? Is he the author of this?
Q. If you will look at the second paragraph.
A. The second paragraph?
Q. It says --
A. Oh, I see. The second paragraph.
Q. I want to direct your attention to the article entitled --
A. The second paragraph that is underlined. I have got you.
Q. If you look at the paragraph entitled "Insurers are Eliminating Markup on Cancer Drugs, Official Says," and in the second paragraph, it says, "'You are going to have to make chemotherapy a cost-neutral equation,' Lee Newcomer, chief medical officer at United HealthCare Corp. of Minneapolis said in a keynote address at the NCCN

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Guideline Conference on March 3rd."
A. Right.
Q. Have you ever heard of Dr. Newcomer before?
A. No, I have not.
Q. The article goes on to say that Dr. Newcomer was an oncologist before he became chief medical officer of United HealthCare.
A. I see that.
Q. So since the chief medical officer of United HealthCare was an oncologist who acquired chemotherapy drugs directly from manufacturers, wouldn't it be safe to assume that United understood as of 1997 that there could be mega-spreads to the extent that they existed at the time?
MR. SOBOL: Objection.
A. The -- what -- what this says to me is that Lee Newcomer understood the allegations in this matter and was making his voice heard, and there -- I'm -- as -- there are no doubt other students and experts in this area that also

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realized to some extent the amount of the kind of spreads that were going on and that they wanted to make them cost neutral.
This is the type of evidence that gathers over time that will ultimately lead to sufficient information to -- for entities to move, like third-party payers, to change and respond to what they realize is -- is a problem, is a situation.
Q. But if United knew of mega-spreads as of 1997, then United could not have been deceived; is that correct?
MR. SOBOL: Objection to the form.
A. I -- the -- I don't know which drugs. I don't know if this says all the drugs. I see that it says, "You are going to have to make chemotherapy" -- no, I don't see the list of drugs here.
(Pause.)
(The witness viewing Exhibit Hartman 033.)
A. So I see it talks about some of the

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administrative issues that would be involved in terms of the accounting issues.
Is this the same? I don't know. It is a different article.
Q. Would you agree with me, Dr. Hartman, that if a payer knew of mega-spreads then that payer could not have been deceived by mega-spreads?
MR. SOBOL: Objection to form.
A. I would agree with the following: that if -- if over this period of time there is sufficient information that a given payer came to realize that there were mega-spreads and that they were -- they essentially covered the spectrum of physician-administered drugs, that that payer would begin to understand -- to realize that there was -- they were being damaged to the extent that these spreads were leading it to pay more than it should have paid, should be paying for the drugs, and that over some period of time that would end up being reflected in decisions that at a corporate level of how to change reimbursement

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that has been tied to AWP for 20 years. And so there is -- there is a realization of for some drugs, and then there is a realization of how uniform, how consistent it is over all the other drugs, and then are we going to -- how are we going to change our system and do a cost effectiveness analysis to protect ourselves.
And all through that process, realization to finally acting on it, which is what I am saying is that revealed behavior that I want to see, they are being damaged -- they are still being damaged by a set of expectations that started, and they haven't -- they can't turn on a dime.
Q. Dr. Hartman, I asked you whether a payer who knew of mega-spreads could have been deceived by mega-spreads. Can you give me a direct answer to that question?
MR. SOBOL: Objection.
You don't need to answer that question.
A. A payer who came --
MR. SOBOL: You don't need to answer

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that question. You just -- he just asked you the question. You gave an answer. He now asked for a direct answer. You gave him a direct answer.
THE WITNESS: I guess I don't have to answer that question.
MR. EDWARDS: You are instructing the witness not to answer?
MR. SOBOL: Yes.
BY MR. EDWARDS:
Q. Do you know how many --
MR. SOBOL: I can make a record why. We only have so much time. You can't ask him to answer the same question twice in a row. We are trying to save some time here, Steve.
Q. Do you know how many third-party payers have chief medical officers?
A. I would assume that it -- I would hope that it would be a common practice.
Q. And do you know the extent to which payers have chief medical officers or other employees who were oncologists?
A. I don't know the exact representation.

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Q. Do you know the percentage of covered lives that United represents in the United States today?
A. Are we talking now about covered lives for all medical services? For self- administered drugs? For -- for the percentage of physician-administered drugs? What -- what is your -- what is the focus we're getting at here?
Q. Do you know the answer to any of those?
MR. SOBOL: Objection.
A. They're big.
Q. They are one of the biggest; right?
A. That's right.
Q. In fact, it is between United and Anthem as to which one is the biggest at the present time; correct?
A. Well, United -- is this United as a PBM or United as a payer?
(Pause.)
(The witness viewing Exhibit Hartman 033.)
A. It is a big organization.

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Q. Do you know whether Medicare was aware of mega-spreads in 1997?
MR. SOBOL: Objection.
A. I know there was increasing information regarding the extent to which reimbursement based on AWP was leading to payments that were felt to be out of -- to be too high.
Q. And would you agree with me that if Medicare knew of mega-spreads then it could not have been deceived by mega-spreads?
MR. SOBOL: Objection.
A. No. The -- the -- I think the OIG report you are referring to in '97 is a calculation of what the overcharges for Medicare -- on Medicare drugs were, and, yes, there were overcharges.
The extent to which those were mega-spreads -- that talks about spreads being higher than what they had anticipated they were and that they were higher than -- I don't think they necessarily came to the conclusion they raised, reached the level of Vincasar and Lupron that we

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saw, but they began to realize that the reimbursement at AWP was a profit center and an increasing profit center to physicians, and it was costing Medicare money, and so there was information out there, and as I have said, information gathers, and it alters expectations in a -- in a -- in a slow way that is ultimately reflected in behavioral changes, and we see a Medicare understanding of what is going on, understanding that what their earlier expectations have put them in a position where they're paying too much, and by the time they're able to change those kinds of reimbursement policies, it is 2005.
So yes, there can be some understanding, but it doesn't mean that they didn't have -- their earlier expectations was what guided their decision to get into that reimbursement policy to begin with, and it takes a long time to change those kinds of things around. So, yes, they began to understand it, but it doesn't men they got -- that they suddenly -- that they were free of the impacts and the damages of this, of the alleged

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inflation.
Q. Now once they understand it, they are no longer deceived, assuming they were deceived before; correct?
MR. SOBOL: Objection.
A. They are locked into a situation that they're paying more than they thought they would be when they originally entered into that kind of reimbursement scheme.
Q. Do you know why it took Medicare the amount of time it took to change the reimbursement scheme as you just testified to a moment ago?
A. I haven't studied the statutory history closely.
Q. Well, would it surprise you to learn that Medicare wanted to change the reimbursement scheme but Congress wouldn't let them?
MR. SOBOL: Objection.
A. I haven't, you know, I haven't focused -- I haven't done an analysis of that.
Q. And I take it that it is not within the purview of your testimony to second-guess the

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policy decisions of Congress, is it?
MR. SOBOL: Objection.
A. I have -- I have not been asked to do any analysis of the Congressional record.
Q. Nor are you suggesting that the Court should second-guess the policy decisions of Congress, are you?
MR. SOBOL: Objection.
A. I -- I am making no suggestion one way or the other.
Q. Okay.
MR. EDWARDS: What I want to do is mark as Exhibit Hartman 034 a copy of a letter from Zachary Bentley and Mark Jones to Dr. Bruce Vladeck dated October 2, 1996. The Bates numbers are HHCOO 3- 0479 through 0484.
(Letter dated October 2, 1996 to Dr. Vladeck from Mr. Bentley et al, production numbers HHCOO 3-0479 through 3-0484 marked Exhibit Hartman 034 for identification.)
(Handing Exhibit Hartman 034 to the witness.)

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BY MR. EDWARDS:
Q. Have you ever seen this document before?
(Pause.)
(The witness viewing Exhibit Hartman 034.)
A. Not that I recall.
Q. If you look at the second paragraph, it states, quote, "Enclosed with this letter you will find two volumes of exhibits that substantiate and support the fact that the Medicare and Medicaid programs are continuing to make excessive reimbursements to providers for infusion and inhalation pharmaceuticals," close quote.
Would you agree with me that to the extent that those exhibits documented alleged mega-spreads as of October 2, 1996, then Medicare could not have been deceived by alleged mega-spreads as of that date?
MR. SOBOL: Objection.
A. You are -- you -- your notion of deception I think is faulty in the sense that the commitment on the part of Congress and on the part

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of third-party payers reflected an understanding in terms of reimbursement design and information processing design that permeated this industry that was based on understandings earlier in the 1990s, and that turned out to be incorrect, and that turned out, the changes, the fraudulent behavior is based on those understandings and changes in movements away from those understandings and abuses of those understandings.
Now I look at this second paragraph here, and it says, "excessive reimbursements," so I don't see mega-spreads there yet.
I don't know. Maybe they are mega-spreads. I need to look.
But what was clear, and if one looks at the fact record in Lupron, what became clear over the '90s is what started as some slightly overstated reimbursements, seeing how the system could be gamed, increased and increased until spreads became mega-spreads, as resulted in the Vincasar example before that subcommittee.
So, you know, this notion of being

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deceived or not deceived, the issue that I'm getting at here is that there was a set of expectations incorporated into a set of reimbursement practices and procedures that was based on facts and information that reflected pricing in the early '90s and up through the mid '90s, and those things were changed and abused by defendants in this case, as is alleged.

Q. Take a look at the second paragraph on page 3 of this document.

(Witness complying.)

Q. The third sentence of that paragraph says, quote, "Based on these results, we found that Medicare's reimbursement was excessive and in many cases provided profit margins of more than 500 percent and in some instances more than a thousand percent."

Are those mega-spreads?

A. Well, they're getting large. I would say Vincasar had a mega-spread. These are getting to be big spreads. These are spreads that are abusing the system.

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Q. And Medicare certainly had knowledge of the information contained in this letter and the exhibits to this letter; is that correct?

MR. SOBOL: Objection to form.

A. I -- I see a -- I see a memo here directed to Dr. Vladeck at HCFA, and so, yes, the understanding of what was going on with these prices -- with prices became richer and deeper and more complete over the decade of the '90s. I agree.

Q. So Medicare could not have been deceived by the mega-spreads or alleged mega- spreads identified in this document; correct?

MR. SOBOL: Objection.

A. Medicare was locked into a reimbursement system that for whatever reason they were in terms of information coming in like this to the extent that it fully reached all the -- those members that were necessary to make a change and revealing preferences in the way the reimbursements were paid, this was -- this was part of that growing understanding. But I don't know -- to say -- to

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characterize Medicare was not deceived, Medicare -- if Medicare knew everything that it knew and could move, it would have moved earlier than 2005, given the realities in which it was operating.

Q. Take a look at --

MR. EDWARDS: Strike that.

Q. Well, is it your testimony that if a payer has accurate information about a spread but fails to act on that information then the payer is still deceived?

MR. SOBOL: Objection.

A. If a payer has entered into a reimbursement contract and contracts are -- are long-term agreements of how -- what the terms of operation are, that if they enter into a contract that is based on one understanding and they come to understand or they begin -- they start to see information that makes them wonder whether their initial understanding is correct or incorrect, that doesn't mean that they have -- they are still not being harmed, economically harmed, by an agreement or a set of agreements into which they

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have based their decision-making on that reflected a different state of relationships between prices.

Q. I asked you whether they are still being deceived.

MR. SOBOL: Objection to the form.

Q. Are they still being deceived?

MR. SOBOL: Objection to the form.

A. Whether they're being deceived or not is irrelevant. They are being harmed economically.

Q. So you are not in a position to say that a payer who knows of the spread is being deceived?

MR. SOBOL: Objection to the form.

A. I don't know what your economic definition of deceived is. There is a set of expectations that have informed what in general payers and Medicare's thought relationships were, and there may be -- there may be information on one drug, a few sets of -- a few sets of claims.

Everybody seems to be moving around.

MR. EDWARDS: The tape is about to run out.

THE WITNESS: Okay.

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THE VIDEOGRAPHER: The time is 2:32. This is the end of cassette 2. We are off the record.
(Recess taken at 2:32 p.m.)
(Recess ended at 2:39 p.m.)
THE VIDEOGRAPHER: The time is 2:39. We are back on the record. This is the beginning of cassette number 3.
BY MR. EDWARDS:
Q. I want to direct your attention to the fourth page of Exhibit Hartman 034, the bottom of the page.
(Witness complying.)
Q. Do you see where it talks about a drug called Vepesid?
A. I do.
Q. That is a Bristol-Myers drug?
A. It is, I think.
Q. And Vepesid had an AWP of $136.49?
A. I do see that, yes.
Q. And then if you look at the next page, the authors of this document talk about how

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generic competition for Vepesid has caused the price to plummet to $18?
A. Of the -- of -- of the generic? Or is that the price --
Q. It says the price for -- Vepesid is an Etoposide; right?
A. I -- I would have to check on that. I forget what -- if that is the case, but I will take -- assuming that is true, I will accept your claim that that's true.
Q. Okay. And so this document says that, quote, "The price for 100 milligrams of Etoposide has plummeted to $18," close quote?
A. Yes.
Q. Correct?
A. Yes.
Q. And would a spread between $136.49 and $18 be a mega-spread in your view?
A. It is a -- it is a large spread.
Q. And is there any doubt that as of the date of this letter Medicare was aware of that mega-spread?

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A. The -- you are talking about Medicare -- you are talking -- are you talking about Bruce Vladeck? Or are you talking about Medicare? Is Bruce -- is he the –
Q. He is the administrator?
A. He is the administrator of HCFA.
Q. Do you know if HCFA has anything to do with Medicare?
A. I know HCFA has been subsumed under CMS, and they were the -- yes, I guess they would have been running as CMS does Medicare.
So clearly there were cases that were being brought to the attention of administrators within HCFA that this was a problem, and to the extent that HCFA and Medicare understood that this was a global problem as of yet, I can't tell from this letter.
Q. Do you know where in the hierarchy of HCFA the administrator's position stood?
A. No, I don't.
Q. So you're not aware that Dr. Vladeck was the head of HCFA at this time?

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A. I assume he is the administrator from the letter, and I don't know him personally, and I don't know the org. chart of Medicare at that point, so.
Q. You haven't studied the industry extensively enough to be aware of that sort of fact; is that correct?
A. I haven't memorized the heads of Medicare or HCFA going back to 1990, no.
Q. Now do you know whether information about alleged mega-spreads for Vepesid was available to the public generally?
A. Well, one of the things that we should keep in mind here is, you know, there is -- there is -- and this is again the notion about what is deception, what is information, what -- how do people finally act on things.
Right now we're talking about an issue of a multi-source drug and what is the appropriate -- how that should be billed by doctors and whether they are billing it at what they should be billing it at, which is the median of the generic

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price, or the lesser of ASP or the median of the generic price or the branded -- the lowest branded price. That could be the fraud we're talking about here.

This -- the fact that this is going on with multispread drugs doesn't tell me that HCFA or Medicare became aware of mega-spreads for single-source drugs and the kind of fraud that we're -- is also -- is the major focus of what I have been examining.

So, you know, we -- you are throwing around spreads of this and that, but we need to be careful about what we're attributing this to and what -- what information content this has for what aspect of whatever deception you're talking about.

Q. So you would agree with me that at least as of October 2, 1996, there was no longer a case for liability with respect to Vepesid based on alleged mega-spreads?

MR. SOBOL: Objection.

A. No.

Q. Correct?

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A. No.

Q. Let's take a look at a document we previously marked as Exhibit Hartman 007 to your deposition. It is an article from --

A. Exhibit Hartman 007?

Q. -- from the June 10, 1996 issue of Barron's.

A. Oh, I am sorry. I thought I already had it.

(Handing Exhibit Hartman 007 to the witness.)

A. Are we marking? Oh, we are not marking this. It has already been marked.

Q. It has already been marked.

A. I see. Oh, God. I can't read that.

Q. The article is entitled "Hooked on Drugs," and I want to direct your attention to page 16 of the article, or it is actually the page with the number 16 at the top.

A. The page with the number 16?

Q. It is the third page --

A. Here is 15.

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Q. --of the document.

A. Oh, 16. I see.

(Witness complying.)

Q. Do you see where it talks in the left-hand column there about the drug Vepesid?

A. Right. I am starting to see that. It became a generic.

Q. The last full paragraph?

A. Right.

Q. It says that Vepesid had an AWP of about $136?

A. I see that.

Q. And if you continue on to the right-hand column, it says, "Today the market price for 100 milligrams of an Etoposide is around $35"?

A. Um-hmm. I see that.

Q. This would be as of June 10, 1996.

A. Right.

Q. Now is that in your view a mega-spread, the difference between an AWP of $136 and a market price of $35?

A. Well, you are -- the examples you are

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bringing up here is a fraud different than the fraud that -- that is alleged in this matter, and in this matter, it is NDC specific. It is individual manufacturers raising and trying to move market share of, with its AWP relative to its price.

Now you are comparing the AWP of Vepesid with the price -- the market price for a Gensia product, and so if -- if it is a fraud of submitting reimbursement when you are doing the generic and when you are administering the generic and you are using the AWP of the branded drug, that's -- that's different than what we're talking about here with -- of the spreads within NDC, within company.

I mean that being said, we can continue talking about this, but I'm trying to get a sense of where -- it is -- this is a different spread you are asking me to look at than the ones that I have looked at in my report.

Q. Well, assuming that the price that Bristol-Myers was charging for Vepesid was around

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$35 at that time, would it be fair to say that any payer who was aware of the information in this Barron's article would not have been deceived by any mega-spread with respect to Vepesid?

MR. SOBOL: Objection.

A. As -- I mean we can look at a variety of these, and the point is that there are -- this is the kind of information that and these are the venues, as are the OIG reports and the letters to HCFA and what appears in Barron's, that started to make payers and make the industry understand what was the effects of the allegations -- the price allegations, the price inflation allegations in this matter.

So it is not a question of whether they were deceived on the whole. It is -- it is one small piece of information that goes toward making a decision about what you would -- how you would change your reimbursement to avoid this situation, and they were still locked into a reimbursement practice and procedure that a piece of information like this was just something they said, "Okay,

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we've get got to start watching this and looking at the accumulated information.

Q. Well, you said they started to understand. When did they understand?

MR. SOBOL: Objection.

A. As a matter for an economist, one finds that preferences and expectations are revealed when behavior is exhibited, and when there is a shift in the way reimbursement is paid or contractually the way -- what kinds of discounts are offered off of AWP or whether it is related to ASP. That then shows that there has been enough information that they have come to an understanding that is sufficient to make them move to avoid the problems that are slowly becoming clear to them.

I mean it is like the Vietnam war. People said that was a mistake in the beginning. It took 10 years for the country to come to a conclusion about that.

Information is slowly. It builds. Decisions get made, and preferences are revealed.

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Q. I wanted to make sure I understand what you mean when you talk about revealed preferences. What is the theory of revealed preferences?

MR. SOBOL: Objection.

A. Well, the notion of revealed preferences are that economic entities, economic consumers, perhaps producers, for a variety of economic agents, have preferences, have distributions of preferences, and one really understands what those preferences are when they are revealed through an actual economic act or action, a purchase, a purchase at a price, and there you have a revelation of what might be perceived to be a distribution of motives or beliefs or utility valuations, but you reveal your preference given all that you know, given the information you have, given the facts in the market.

Q. Well, I think we established earlier payers understand that providers earn profits on drugs; correct?

A. Correct.

Q. Did it ever occur to you that the reason

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payers did not change their conduct even though they knew about alleged mega-spreads is because they wanted the providers to make profits on those drugs?

A. It's -- it's a possibility that I considered, but the information that I revealed suggested that was not what -- what was the -- the drive -- the reason that they hesitated.

And, secondly, I would think as a matter of business practices, the -- at some level, if that is what is motivating their decisions, then they're -- then that is something that needs to be known to the customers, their customers.

Q. Well, you say that it is a possibility that you considered. How did you consider it?

A. Well, I looked at, like the Young -- as we have gone through in attachment K, what people believed about Medicare, what Young was saying, how reimbursements worked under Medicare, what it implied about the margins, the retail margins that were being earned by the providers, that when the discussions in Congress were going on about

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reducing the reimbursement rate from 100 percent to 95 percent of AWP, that everybody said, "Oh, my God, the providers are going to be killed by this," and which to me suggests they had no idea how much money was being made on this drug, that they were just making basically a retail margin.

So I can look at the discussion and the description of your own experts, summarizing what the debate looked like, and that informs me that they didn't -- while there is -- there is limited information, there is little pieces, little nuggets of information that come to the surface, the overriding notion of this importance of being unimportant was really prevailed in spades for physician- administered drugs and reimbursement. This stuff appeared, but managed care organizations and third-party payers were worrying about a lot of other big ticket items, that this was something that got put on a back burner.

Q. Can you cite to me any evidence that would enable you to conclude -- I am sorry -- that would enable you to reject the possibility that

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providers did not act on mega-spreads because they wanted -- I am sorry.

MR. EDWARDS: Let me start that whole question all over again. Strike that question.

Q. Can you cite to me any evidence that would enable you to reject the possibility that payers did not act on mega-spreads because they understood that providers were making a profit on those mega-spreads and they were willing to let that continue?

A. That sounded like one of my answers. That was -- that was long and involved.

MR. SOBOL: Objection -- to the question.

(Laughter.)

A. What I am hearing you say is do I know of any evidence that where it is demonstrated that the providers said, "Hey, we are paying these guys a boat load, and screw our -- screw our policyholders. We're just going to keep paying them this boat load." And you're saying have I seen any evidence where they knew that and they

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said, "Ah, this is great, we love the providers, let's do it."

I have seen no evidence that would support that, or I have seen no evidence that would reject that. I have seen no evidence that is along those lines.

Q. Are you familiar with Blue Cross/Blue Shield of Massachusetts?

A. I am.

Q. It is your understanding that they're a class representative in this case?

A. I didn't know that, but it is good to find that out.

Q. Have you read the depositions of the representatives from Blue Cross/Blue Shield of Massachusetts?

A. I forget.

Q. Mr. Mulrey, Mr. Killion?

A. I have a feeling your associate is about to bring them for me. I don't remember.

Q. Are you aware of the fact that Blue Cross/Blue Shield of Massachusetts actually did a

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study in which they considered moving from a reimbursement formula of AWP minus a percentage to ASP plus six percent but decided not to?

A. And when was this study done, may I ask?

Q. I believe it was 2004.

A. So this comports with my hypothesis that private sector payers will start to do these studies in view of what they have observed with Medicare.

I am not aware of that study, no. But I would like -- I would be interested to see the materials related to it.

Q. Well, let's take a look at Mr. Mulrey's transcript and Exhibit 2 to his deposition.

MR. EDWARDS: First we will mark as Exhibit Hartman 035 a copy of a document entitled "Analysis of CMS Average Wholesale Price Reform" dated February 7, 2004. It was previously marked as Exhibit 2 to Mr. Mulrey's deposition.

(Multipage analysis of CMS Average Wholesale Price Reform, February 7, 2004 marked Exhibit Hartman 035 for identification.)

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(Handing Exhibit Hartman 035 to the witness.)
BY MR. EDWARDS:
Q. The reporter has handed you Exhibit Hartman 035?
A. Yes, she has.
Q. Have you ever read this document before?
A. No, I have not.
MR EDWARDS: What I want to do is mark as Exhibit Hartman 036 a copy of the transcript of Mr. Mulrey's deposition dated January 5, 2006.
And I should state that a lot of the documents and depositions we are using have been marked "Confidential," so to the extent that those materials are referred to in this deposition, the deposition should be treated confidential as well.
(Deposition transcript of Mr. Mulrey taken January 5, 2006 marked Exhibit Hartman 036 for identification.)
(Handing Exhibit Hartman 036 to the witness.)
BY MR. EDWARDS:

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Q. Let's look first of all at the deposition transcript. I want to direct your attention to the testimony that begins at page 71, line 13.
"Question: --
A. I am sorry. Please just let me get there. I am a little bit behind here.
(Pause.)
(Witness complying.)
A. Okay. Good.
Q. "Question: So in 2004 you learned that Medicare had reimbursed drugs at an amount that was intended to subsidize -- or cross subsidize I believe is the term used -- the inadequate reimbursement of the servicing fee; correct?
"Answer: Yes.
"And based upon your analysis, you determined that following Medicare to the ASP methodology, that would result in a decrease in overall reimbursement afforded to physicians; is that correct?
"Answer: Yes.

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"And as a consequence of your analysis, is it correct that Blue Cross/Blue Shield of Massachusetts elected not to shift to the ASP reimbursement methodology?
"Answer: At this time, yes.
So Blue Cross/Blue Shield of Massachusetts had access to the AWPs that manufacturers currently report to CMS; correct?
MR. SOBOL: Objection.
A. I'm sorry. Say that again, if you would, please?
Q. Blue Cross/Blue Shield of Massachusetts had access to the AWP -- ASPs that manufacturers currently report to CMS; correct?
MR. SOBOL: Objection.
A. It's -- it's -- it seems to suggest that they do. I -- they are talking about ASPs. Whether they are guessing them or whether they have -- I don't know -- I don't know what information.
Q. Well, is it your understanding that ASPs are available to the public now from CMS?

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MR. SOBOL: Objection to the form.
A. I don't -- the -- I know they are provided to CMS, but I don't know what -- whether it is like AMPs, that they are subject to proprietary types of provisions. I don't know what the legal standing is or the proprietary nature is and how -- how that is shared.
If you want to tell me that they are shared and this is what is being reported to CMS from the manufacturers, then I will -- I will take that as then that that's the case. I don't know what the legal requirements are on the part of CMS to release that kind of information to payers, but.
Q. And what Mr. Mulrey is saying in his testimony is that we considered switching to an ASP-based system but decided not to; correct?
A. He is certainly -- he is saying that, yes.
Q. And he is suggesting in this testimony that one of the reasons they decided not to is because they understood that the profit that the

834

physician earned on the drug compensated for an underpayment to the physician on the services; correct?

MR. SOBOL: Objection to form.

A. Well, what I'm seeing, again putting a little -- into a little bit of context, which I find is helpful to me and maybe to the Court, I mean looking back at page 69 about Mr. Mulrey's involvement in this project, he is asked whether he had any understanding under Medicare whether it was adequate -- whether the service fees were inadequate or not and about -- whether drug reimbursements provide that margin, and I see that he says he didn't really have much of an understanding, and that the information that was brought, he started reading about it, that he understood these kinds of differences, which indicate again to me the fact that this is information that various people in at the policy level come to be aware of this will at different times, that it can affect decisions, and here is clearly a time when it is affecting, some

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preferences can be revealed.

As we have talked about revealing preferences, and I don't know what ASPs are being focused on here, but certainly as they are revealing a preference, they -- what I am seeing is being said here as of -- so they learned it in 2004, and so now they are trying to make a decision -- I don't know if this is for 2005 or when this is for -- that they are going to continue to live with an inflated spread and overpayments for the reason of a cross subsidization.

So that is -- is what I see this is reflecting.

Q. So the Blue Cross/Blue Shield of Massachusetts situation demonstrates that it is possible for a payer not to be deceived as to spreads and yet decide to continue to reimburse on the basis of AWP the way it always has?

MR. SOBOL: Objection.

A. What I read this as saying is that by 2004 they're finally becoming aware of this. It is

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on their radar screen that they want to make a decision about it. And they have decided to continue to pay -- they understand that they have, for the past 10, 15 years, have been paying more than they should have. They have been locked into a reimbursement schedule, and that -- that they were still -- they were in it, and they were going to -- they -- they elected to stay in that schedule. They intended to continue to overpay for those pharmaceuticals, and as a -- that would cross subsidize other payments to physicians.

Q. By the way, you referred earlier to what you called the long-term agreements in the industry. Have you done an analysis of the terms or the term period of agreements between payers and providers with respect to physician-administered drugs?

A. I have reviewed contracts generally, and I have seen contract lengths anywhere from a year to three years. There may be ones that were shorter and longer.

Q. And are you aware that many of those

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contracts have termination provisions that would enable either side to terminate on a specified number of days' notice, such as 60 or 90 days?

A. I forget what the term -- what the termination notices might have been.

Q. You're not in a position to opine that the length of the contracts between payers and providers prevents payers from reacting to information they find out about concerning the spreads, are you?

MR. SOBOL: Objection --

A. No.

MR. SOBOL: -- to form.

A. No.

Q. Do you know whether other payers have considered moving to an ASP-based reimbursement system but have rejected it?

A. I know of no other specific payers that have done this analysis and have come to this conclusion.

MR. EDWARDS: Let's take a look at Mr. Killion's deposition, which we will mark as

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Exhibit Hartman 037. This was taken on January 6, 2006.

(Deposition transcript of John Killion taken January 6, 2006 marked Exhibit Hartman 037 for identification.)

(Handing Exhibit Hartman 037 to the witness.)

BY MR. EDWARDS:

Q. I want to direct your attention to page 89 of this deposition, beginning at line 2.

"Question" --

A. I am sorry. Mr. Killion is? So he is at Blue Cross/Blue Shield of Massachusetts also? Okay. I see.

Q. He is senior director, ancillary services of Blue Cross/Blue Shield of Massachusetts. That appears on page 6.

A. Okay. And I am sorry. The page that you directed me to?

Q. Page 89.

(Witness complying.)

Q. It reads, "Question: You had mentioned

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that Blue Cross/Blue Shield had made the determination not to reduce reimbursement under the ASP methodology. Is it your understanding that the industry standard is to maintain reimbursement at 95 percent of AWP?

"Answer: My understanding is not to -- the industry standard is not to move to ASP at this point in time.

"Question: Right. My question is a little different. Is it your understanding that the industry standard is to maintain reimbursement at 95 percent of AWP?

"Answer: For the most part, yes. That's correct."

Dr. Hartman, isn't the fact that Blue Cross/Blue Shield of Massachusetts and most of the rest of the industry has decided not to go to an ASP-based reimbursement system, notwithstanding the availability of ASPs to the marketplace, inconsistent with your revealed preference analysis?

MR. SOBOL: Objection to the form.

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A. No.

Q. Do you want to answer my question?

A. I just did. No.

It was, I know, a very short answer, so it probably surprised you.

Q. Well, is it your testimony that Blue Cross/Blue Shield of Massachusetts and the other payers who have not decided to go to an ASP-based system are deceived?

A. It is my opinion that we are at a stage when this information has become sufficiently prevalent that it is starting to rise to the surface where entities are beginning to understand the extent to which the AWP-based reimbursement is leading to mega-spreads, and they are -- there is -- there are -- the phenomenon of the importance of being unimportant, that this essentially has been one of the last things that gets turned to, the notion of status quo bias where, for various institutional reasons and information technology reasons you are locked into a certain reimbursement system that was based on other

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expectations, that these payers are starting to make those decisions, and these decisions are being made right now, and this man is reflecting something as of 2006, and as we have seen over the -- as we have seen from 1994, '3, you were giving me information that was informing Medicare. It took them 10 years to finally institutionally understand and reveal the preferences of moving to an ASP system.

So this doesn't contradict anything that has been put forward here. They have yet to reveal how they are going to respond when they commit to changing the -- a system that has been put in place based on older expectations that have since been violated.

Q. You characterize your report as a report on liability; correct?

A. My report deals with issues of liability, thresholds of liability, and measures -- measures of causation of when spreads will exceed a measure of liability and a calculation of damages.

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Q. So you are rendering an opinion on liability in this case?
A. I am rendering an opinion where the economic facts that are revealed in this market demonstrate certain results that exceed thresholds of liability that I have been asked to assume. One is a -- the understanding of what the sticker price, how it was a signal for transactions prices, and how that became hard wired into a reimbursement system for what turns out to be a small item on the -- on payers' radar screens, and I have also been asked to apply that methodology to another threshold of liability that has to do with Medicare reimbursement where a threshold is a zero spread.
Q. You just said that you have been asked to render an opinion on the thresholds of liability that you have been asked to assume. Are you assuming liability here?
A. No. I am -- let me clarify. I don't know if that is exactly what I said. If it is, it should be nuanced a little bit more.

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I have been asked to render an opinion on observations of pricing behavior and what an understanding and expectation of the relationship between a list price and transactions prices that informed reimbursement rates over this -- over the class period. I have been asked to look at measures of those prices to see whether they exceeded measures that reflected what was reasonably expected as a relationship between that sticker price, that list price, and transactions prices.
So I was first asked to look at the facts, look at how -- whether those prices and those spreads exceeded a measure that defined a market understanding.
I have also been asked to look at the same set of facts -- so that was the first -- I wasn't told to look at 30 percent. I was told go and find out what was a reasonable expectation of this relationship, what did the data suggest, what was revealed, and I did that.
I was also asked in my supplemental

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report to look at a different level of threshold, and that was a zero threshold, that relates to the Medicare statute.
Q. Are you rendering an opinion on deception in this case --
MR. SOBOL: Objection.
Q. -- on whether payers have been deceived?
MR. SOBOL: Objection.
A. I am rendering an opinion on whether manufacturers altered the relationship between their list price and transaction prices in ways that were not understood by payers and ways that deviated from what payers had understood those relationships to be in order to effectuate their own market strategies.
Q. So you are not rendering an opinion on whether payers have been deceived?
A. The -- if -- if the payers didn't understand -- I have just -- I essentially told you what I am rendering an opinion on. You can call it deception or whatever you want.
There was a set of expectations that

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were built in, and did manufacturers exploit an understanding that was hard wired into a reimbursement system that permeated physician-administered drugs up until about 2004.
Q. So the answer to my question is, yes, I am rendering an opinion on whether payers were deceived?
MR. SOBOL: Objection to the form.
A. I just -- I gave you the -- my answer. That's what it is.
You like the -- you seem to love the word "deceived." I have put it in my words, in the words of an economist.
Q. Do you have a definition of deception?
A. I have a -- I am an economist. I am not a lexicographer. I have given my description of the economics that I observed here and how the economics deviate from what the understanding of the payers were, and that's -- that's my understanding of what -- what I was asked to explore and see if there was such a deviation and that that was a measure of damages and injury, and

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if you want to call that deception, then -- then that --
Q. So you don't have a definition of deception that you are using in connection with your testimony in this case?
MR. SOBOL: Objection.
A. I -- my definitions and my analysis, I have just summarized. I don't -- I'm -- I don't know where in my report I talk about deception.
Q. Is it your testimony that Blue Cross/Blue Shield of Massachusetts and other payers who had access to ASPs but decided not to go to an ASP-based reimbursement system were deceived?
MR. SOBOL: Objection.
A. It is my opinion that -- let's -- let's bring it home specifically to Blue Cross/Blue Shield of Massachusetts.
That for a long period of time, these payers, the little bits I have read, the snippets I have read, I haven't read the whole thing, they have come to look at this more closely very

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recently, so the extent to which these spreads were mega-spreads or were large or the payments were excessive is only something that they have recently been able to systematically understand and factor into their decision-making process, and so this is -- they now -- they -- they understand what the real -- what the real spread is, and if you want to call it that they were deceived before, they -- they had a -- they had an understanding of what the spreads were. Suddenly they revealed, oh, they are different than that.
You can -- you can use whatever adjective you want for that state of their mind -- state of their institutional mind. And now they are making some decision about what do they want to reveal, what preferences will be revealed in how they are going to alter their reimbursement rates and whether they are going to continue to allow themselves to pay -- to abide by a system that was institutionalized when they had one set of expectations and continue to overpay because they want to use those funds to cross subsidize

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some other activity, some other service.
Q. You just said in that last answer that they understand what the real spread is, so it would follow from that that, at least at this point, they are not deceived; correct?
MR. SOBOL: Objection.
A. They -- I don't know what CMS is allowed to release legally. I see a mention of ASPs here. I don't know whether they have looked at all their drugs. I see some -- I see some bullet points, and I see there is some analysis. I don't know how thorough it is. It is clear they now feel like they have a better feel for what ASPs or some ASPs or the majority of their ASPs are, and they have come to some conclusion that they are paying more than they thought, and, ah-ha, okay, so what are we going to do about this, and they have decided to continue to pay more than they thought they were paying, and that those overpayments will essentially cross subsidize some other activity.
Q. So the Blue Cross/Blue Shield of Massachusetts example demonstrates that it is

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possible for a payer to have an understanding of what the real spread is but not change its conduct for other reasons?
MR. SOBOL: Objection.
A. Well, the primary thing it demonstrates to me is that until 2005 no payer could really understand what the spreads were on any drug because the ASPs weren't really available systematically, so there couldn't really be an informed decision along any lines, if this is in -- this seems more informed than other decisions.
You have put in front of me selective things along this drug there is this spread or that spread, but that is not enough for a payer to alter a reimbursement system that was put in place 10 or 15 years ago based on an understanding of the market.
This is systematic, and this is telling me that if CMS now offers these ASPs to payers, they can start to evaluate that, but they are only able to finally systematically evaluate that now since 2005.

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(Pointing to Exhibit Hartman 037.)
Q. If a payer does not change its conduct in response to new information, then that would be inconsistent with your inference that payers did not change their conduct because they did not have information with respect to the spreads?
A. Could you read? I didn't understand that question.
Q. Well, you are making an inference that because in the '90s payers did not change their conduct with respect to reimbursement rates they must not have had information as to the actual spreads; correct?
A. I --
Q. That is how your revealed preference theory works in this case?
A. What I am saying is that I find that over that period of time that there wasn't major shifts in -- in the information that I'm seeing revealed in -- that I use for my yardsticks.
Now if I were to see in contracts and negotiations and in surveys that Medpac undertook

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or whatever that there were -- that the people reimbursing at ASP, that some of their third-party payers were doing that or reimbursing at AWP less 60 percent, but I am not.
I am seeing it is the same -- they are revealing the same kind of contractual reimbursement rates that were reflective of 10 years before that.
And so I am not -- that's the behavior I observe. Now what -- it is clear that underlying that there was a growing awareness anecdotally, a Barron's article here on one drug, another set of drugs here, the OIG would do several multi-source drugs in '92, they would look at a set of drugs, let's say, in '96 and '97, but the kind of systematic data that allows a company to do a strategic evaluation, like Mr. Killion has done, I am assuming this means that CMS releases these ASPs, and finally one can do this.
All I am saying is that I don't see -- and here they have decided not to do it. Now maybe no one will decide to do it.

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But what I am saying is I look in the past. I don't see any revealed movement away from a system based on the -- what the old understanding was, and I don't see any ability to get systematic transparent information on all the ASPs that payers will pay for in order to understand the implications.
Q. Doesn't the example of Blue Cross/Blue Shield of Massachusetts reveal that contract prices don't tell you anything about payer expectations with respect to the spread?
MR. SOBOL: Objection.
A. No. It tells me -- where was the page that you had me look at, if you could be so kind? Do we have that in the record?
Q. I believe it was Mr. Killion's deposition.
A. Yes. I have Mr. Killion's. The page I was curious about, I can't remember where that was.
Q. Page 89.
A. Thank you. Actually, that couldn't have

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been the page, unless I'm -- well, that interim discussion about what he knew when that just preceded the discussion that I had read into the record, I'm not finding that relative to page 89.
So I am sorry. Let's not bother going there.
What was -- is there a question pending? I have kind of forgotten where we were, because I can't find the particular quote that I was looking for.
(Prior question was then read.)
MR. EDWARDS: I think you have answered the question --
THE WITNESS: Oh, good.
MR. EDWARDS: -- to my satisfaction, unless you want the question read back again.
THE WITNESS: No.
BY MR. EDWARDS:
Q. Now I believe you acknowledged that one reason Blue Cross/Blue Shield of Massachusetts may have decided not to change its reimbursement formula is because they wanted the providers to

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make a profit on the drugs in order to make up for underpayment on the services portion of it; correct?
A. My recollection was that they wanted to cross subsidize services fees.
Q. Okay.
A. I don't know if it was to make up for underpayments or --
Q. And another reason a payer might decide not to change from an AWP-based reimbursement system is they simply want to use the prospect of profitability as an inducement to providers to get them to join their network; correct?
A. Well, certainly the entire notion on the part of manufacturers, as I have developed in my affirmative declaration, is that the use of increasing spread is to move market share. So the more -- the greater there is this ability to have that kind of -- that kind of spread that you can use to cross subsidize certain activities and get more doctors in and get more patients and sell, that would be part of moving market share.

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Q. Is it your understanding that payers compete for physicians?
A. I have not looked closely enough at that issue to draw an opinion.
Q. You haven't looked at competition among payers at all?
A. Well, I have looked at competition among payers in the broad context of the structure of the industry, but for the specific example of whether they are competing for doctors to join their networks, I -- I -- I haven't looked at that issue.
Q. Let's take a look at another Medpac report. This one was previously marked in your deposition as Exhibit Hartman 020.
(Handing Exhibit Hartman 020 to the witness.)
THE WITNESS: Yes, I have got one.
Q. Have you ever read that document before?
A. At one point, I reviewed this in my -- in -- in developing my original affirmative declaration, but it has been a while since I

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looked at it.
Q. I want to direct your attention to page 17 of this document, the section headed "Factors that Influence Fee Change Decisions."
(Witness complying.)
Q. And do you see that there is a description of an analysis Dyckman & Associates did of the factors that influence fee change decisions among payers; correct?
A. I -- I see that it -- there is that section, and -- and I am turning to the accompanying Exhibit 14. Okay.
Q. And do you see that the top three factors are the impact of fee changes on claims cost and premiums, the impact on the plan's ability to maintain an adequate provider network that meets customers' access requirements, and parity consistency with competitor fee levels? Is that consistent with your understanding?
A. I am going to -- let me just look at this a little more -- with a little more background so that I fully understand it.

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(Pause.)
(The witness viewing Exhibit Hartman 020.)
Q. Dr. Hartman, do you know anything about how payers negotiate with providers for physician-administered drugs?
A. I --
MR. SOBOL: Was the other question withdrawn?
MR. EDWARDS: Yes. I will withdraw the prior question.
THE WITNESS: I was getting into this.
MR. SOBOL: Just roll with it.
THE WITNESS: It's a joke. It's a joke.
A. Oh, we are into the second question.
I have looked at proforma contract offer sheets pulled together either by PBM's or third-party payers that are starting points of negotiation with other entities, and I have looked at the -- at some of the things that are reflected in the negotiation, so that I -- but so that I have a general understanding, but -- but I don't

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recall precisely what they were.
Q. Do you recall whether these things that you looked at related to negotiations between payers and providers for physician-administered drugs?
A. I certainly saw some for physician-administered drugs is my recollection.
Q. Can you identify them?
A. Do you have my -- my rebuttal declarations here? I bet you do.
Q. You can't identify them off the top of your head?
A. Well, I -- I -- they are cited -- I think they are cited therein, and I think I have got examples therein, but I don't -- I don't remember, of the many entities that I have looked at in the various contexts, I don't keep a tabulation of them. It is more --
Q. Other than what you say in your rebuttal report on class certification, I take it you have not done a study or an analysis of how payers negotiate with providers for physician-

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administered drugs; is that correct?
A. Beyond what I have just said, in looking at these offer sheets and how they start doing it and reviewing the materials that had been cited elsewhere, I have done no independent study, no.
Q. And I take it you are not in a position to dispute the conclusion of Dyckman & Associates in Exhibit Hartman 020 to your deposition on page 18 that "one of the most important things payers are interested in is the ability to maintain an adequate provider network that meets customers' access requirements"?
A. No, I would not. I would think that that is important.
Q. And "one way in which a payer might induce a provider to join its network is by assuring the provider that it can make a profit on the relationship"; correct?
A. The -- there are many avenues in which doctors can be -- providers can be incentivized, and that is one of them, as is the return to practice on the part of manufacturers, so, yes, it

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is obviously -- a provider is not going to enter into an arrangement with a payer if it is derisory or does not allow for a reimbursement.
Q. So the desire to have an adequate provider network might be another reason why a payer would not change its reimbursement formula even though it had knowledge of actual ASPs; correct?
A. I'm -- I have not done enough of a study to be able to assess or respond to that. I mean the -- the particular physicians that we are talking about are specialists in various sorts, and they essentially have considerable market power, and for them to rely strongly on a provider -- a plan's -- oh, I see this is to maintain adequate, meets customers' access requirements?
You know, the abilities -- the particular monopoly power or the market power on this side of this negotiation in my view would be with the providers as opposed to the payers, but it is clearly important to the payers, too.
Q. You think providers have market power?

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A. I think providers that have a specialty such as urologists or oncologists, dealing with let's say prostate cancer, yes, they -- I think they are -- they have -- they have market power.
Q. What impact does that market power have on reimbursement rates for drugs?
A. Well, certainly the fact that physicians have or providers -- well, let's say physicians -- have market power is why they are targeted as the movers of market share by the manufacturers, by the AWP and price inflation that is alleged in this matter.
The reason that doctors can shift their patients from Lupron to Zolodex or back again is certainly what was the most compelling aspect about those companies using return to practice to try and move market share, and that was based on the fact that the doctors were in a, with the physician- administered drugs, the relationship is particularly important, the physician's position in terms of prescribing a therapy and implementing that therapy, and that is something that usually

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would not be second-guessed by a payer, and those decisions are made by docs, and docs have the power to make those decisions and shift patients.

Q. So the market power of doctors is one reason payers would permit doctors to earn a profit on drugs; correct?

A. I -- the -- I haven't looked at -- I know of no studies that have focused on why they would allow them to do that. The -- my understanding and what we're certainly seeing when the -- when the providers -- when the payers learn that there is an abuse of on the part of the providers is that there is a response to that. So it is -- if you are telling me that all payers are trying to accommodate this market power, I don't -- I'm --

Q. Well, are you saying that there is no relationship between the market power of doctors and the reimbursement rates that payers pay for drugs?

A. I'm saying that the reimbursement rates that doctors -- that payers reimburse for

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physician-administered drugs, doctors have had this market power for the last 15 years, the last 20 years, and there has been a difference in how that -- this market power has been used and strategically incentivized, and it hasn't been on the part of payers responding to physicians or in some regard some strategic behavior there. I am seeing it on the part of the manufacturers offering return to practice to the doctors, and I'm seeing that the payers -- part of the reason that they may have not responded as quickly is that they -- that they don't know what these ASPs are and the doctors have the information and they have the market power.

Q. Changing the reimbursement formula is not going to change the market power that providers have in negotiating contracts with payers, is it?

A. Changing the reimbursement formula will change the ability of incentivizing providers to use -- to move market share for certain pharmaceuticals using the spread. It will be on a

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price-based basis.

Q. But the providers' market power is a constant; right? It will remain the same irrespective of the reimbursement formula that is used?

A. I haven't -- I haven't done an analysis. I can't render an opinion on that.

Q. Well, in connection with your reimbursement or expectation yardstick, you suggest that payers are willing to reimburse providers for an amount that is up to 30 percent greater than ASP; correct?

A. I'm saying that that's what the market information that I have relied upon demonstrates to me.

Q. Payers are willing to let providers make a profit of at least 30 percent on the drugs; correct?

A. It -- depending on the reimbursement. I mean if it is AWP less 15 percent, then it is not going to be 30 percent. If they are reimbursing at AWP, then it would be 30 percent. If they were

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reimbursing at AWP plus 10 percent, it would be 40. More. But it depends on the reimbursement, the formula, the reimbursement formula, which we find in Medpac.

Q. Right. And that allowed profit, if you will, is something that results from the providers' market power?

MR. SOBOL: Objection.

A. The market power is the fact that the types of physicians that are making use of physician-administered drugs, administering them in their office, usually oncologists, these are specialty drugs. They are specialists.

The market power arises from that kind of specialty and those kind of credentials and that ability to attract patients as such that the patients will come to them for whatever, for their problems, and then they will accept their opinions as to the appropriate drugs to be administered in their -- in their treatment.

Q. Right. In other words, the first 30 percent above ASP is attributable to physician